THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3159.M5

MDR Tracking Number: M5-04-3519-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on June 15, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the issues of medical necessity. The supplies, therapeutic exercises, group therapy, and levels I, II, and III office visits that were denied with U from 11-06-03 through 12-31-03 **were** medically necessary. The massage therapy denied with U from 11-17-03 through 12-24-03, **were not** medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-31-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
11-10-03 11-11-03 11-12-03 11-13-03 11-14-03 11-17-03 11-18-03 11-20-03 11-21-03 11-24-03 11-26-03 12-01-03 12-03-03 12-05-03 12-08-03 12-10-03 12-23-03 12-24-03 12-29-03 12-31-03	97139-EU	$18.25 x 20	$0.00	F	$0.00	Medicare Fee Schedule, Ingenix	Rule 134.202 (b) states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Per Ingenix the requestor billed an invalid code and modifier for electrical stimulation-attended. Therefore in accordance with Rule 134.202 (b) effective 08-01-03 no reimbrsement is recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
11-10-03 11-14-03 11-24-03 12-01-03 12-08-03 12-10-03	99212-25	$41.91 x 6	$0.00	O	$41.91	Medicare Fee Schedule	Requestor submitted relevant information to support services billed. Therefore, recommend reimbursement in the amount of $251.46.
11-21-03	99213-25	$58.99	$0.00	O	$59.00	Medicare Fee Schedule	Requestor submitted relevant information to support services billed. Therefore, recommend reimbursement in the amount of $58.99.
12-22-03	97750-MT 95851	$100.20 $30.60	$0.00	F G	$33.41 x 3 $30.61	Medicare Fee Schedule, Ingenix CCI edits	Per Ingenix CCI edits Medicare does not allow 97750-MT and 95851 to be billed on the same day. Therefore, reimbursement is recommended for the 97750-MT in the amount of $100.20. However, reimbursement for the 95851 is not recommended.
12-23-03 12-24-03 12-31-03	97150	$21.38 x 3	$0.00	N	$21.38	Medicare Fee Schedule	Requestor submitted relevant information that meets the documentation criteria for services billed. Recommend reimbursement of $64.14.
11-06-03 11-10-03	99070-refreezable Cryo packs 99070-consumable TENS supplies	$18.33 $25.00	$0.00	O	No relative value unit	Medicare Fee Schedule	Requestor submitted relevant information to support services billed for the refreezable cryo packs. Therefore, recommend reimbursement in the amount of $18.33. The requestor did not use the applicable CPT code for the consumable TENS supplies billed that was in effect at the time service was rendered. Therefore, per rule 134.202 (b), payment for this service is not recommended.
11-17-03	98940	$30.13	$0.00	F	$30.14	Medicare Fee Schedule	Requestor submitted relevant information to support services billed. Therefore, recommend reimbursement in the amount of $30.13.
12-08-03	98943	$27.97	$0.00	F	$0.00	Medicare Fee Schedule	CPT code 98943 reports a procedure, service or supply that is not covered or valid for Medicare. Rule 134.202 (b) states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers'

							Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Therefore, reimbursement is not recommended.
12-18-03	99080-73	$15.00	$0.00	F	$15.00	Medicare Fee Schedule	Requestor submitted relevant information to support services billed. Therefore, recommend reimbursement in the amount of $15.00.
TOTAL		$621.82					The requestor is entitled to reimbursement of $538.25.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 11-06-03 through 12-31-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 19th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

August 27, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3519-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

While collecting tools next to a forklift, the operator of the forklift raised the bucket that caught the patient's right knee and lifted him off the ground. He experienced pain and swelling in the knee and was treated in a non-surgical manner. On 12/12/03 he underwent surgery for a partial medial meniscectomy. He then returned to chiropractor and rehabilitation treatments.

Requested Service(s)

Supplies (biofreeze), therapeutic exercises, massage therapy, group therapy, and levels I, II and III office visit for dates of service 11/06/03 through 12/31/03.

Decision

It is determined that the supplies (biofreeze), therapeutic exercises, group therapy, and levels I, II and III office visit for dates of service 11/06/03 through 12/31/03 were medically necessary to treat this patient's medical condition. The use of massage therapy was not medically necessary in this case.

Rationale/Basis for Decision

Medical record documentation indicates the patient underwent a reasonable trail of conservative care with the chiropractor prior to surgery on 12/12/03 and then resumed physical therapy treatments with the chiropractor after that point therefore the supplies (biofreeze), therapeutic exercises, group therapy, and levels I, II and III office visit were medically necessary to treat this patients condition.

The Work Loss Data Institute indicates that pre-surgical care should consist of weight bearing and home exercises. Massage therapy is not recommended in the guidelines (Work Loss Date Institute – Knee Guideline, WLDI, Corpus Christi, Texas 2003) and therefore is not medically indicated for this injury.

Sincerely,